THE PRIVATE INSURANCE MARKET: THE INFLUENCE OF NEW PAYMENT AND DELIVERY MODELS

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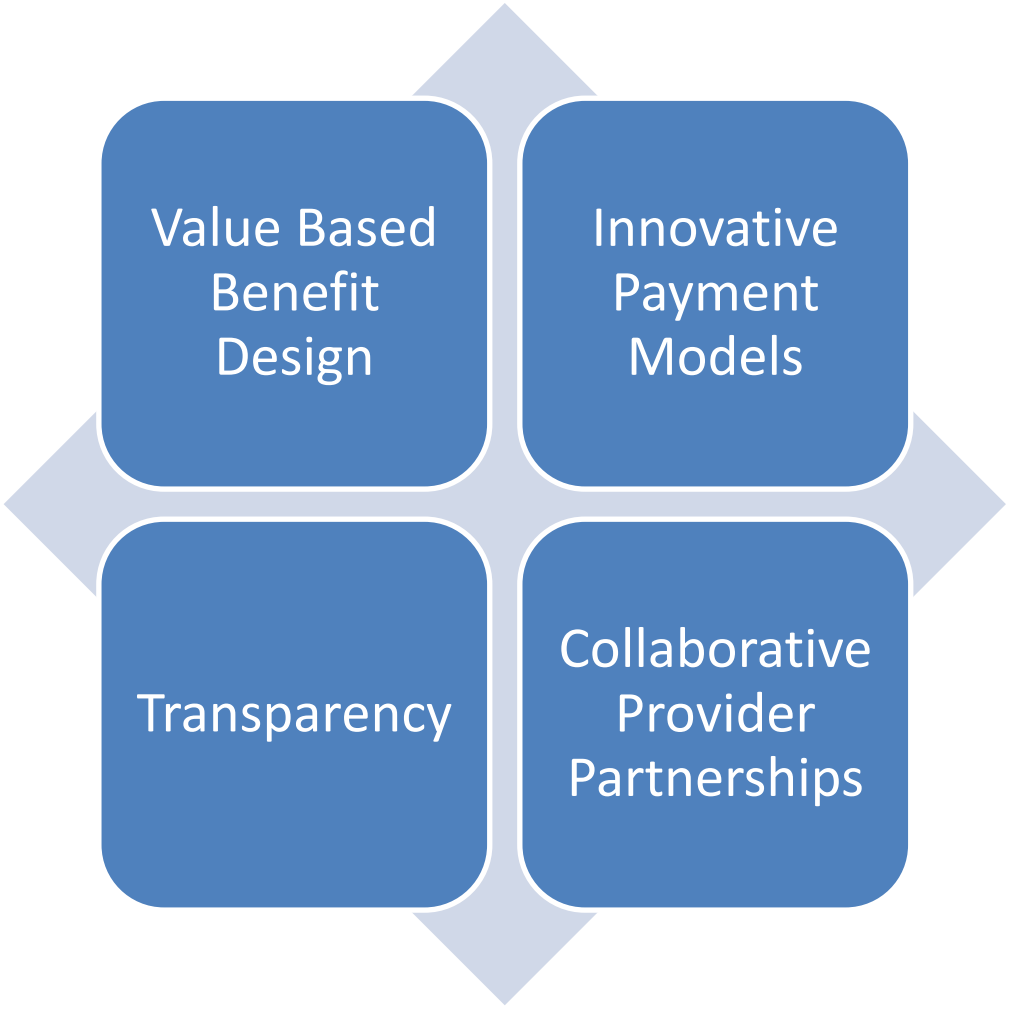
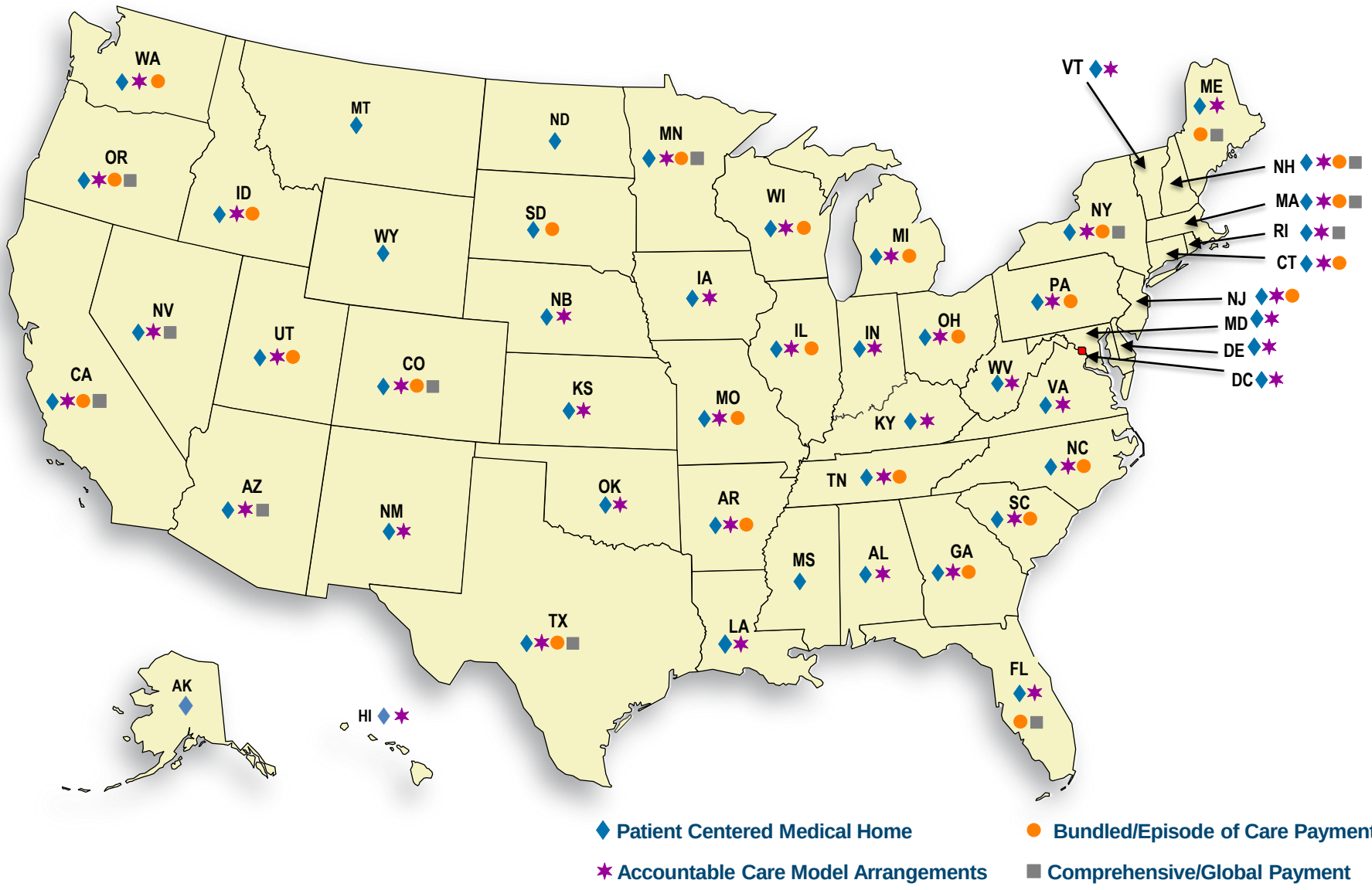
Plans Driving a Move Toward Value



AHIP
America's Health Insurance Plans

Delivery and Payment Models—Private Sector Initiatives



NOTE: Icons may represent multiple partnerships within the state

*The map is current as of January 2015. As new programs are identified the map will be updated accordingly.

Key Technical Assistance

- Population Health Management
  - Providing multiple data and report formats, including:
    - Detailed claims data
    - Analytic reports

- Disease and case management/tools for care improvement and decision making
  - Connecting providers with health plans' disease and case management services by:
    - Embedded nurse case managers
    - Clinical decision-support tools
    - Monthly clinical sessions and collaboration between health plan care management teams and providers

Source: Aparna Higgins, Kristin Stewart, Kirstin Dawson and Carmella Bocchino, Health Affairs, 30, no.9 (2011):1718-1727, Early Lessons From Accountable Care Models In The Private Sector: Partnerships Between Health Plans And Providers

Key Technical Assistance, cont.

- Exchanging health information
  - Two-way flow of information to facilitate case management and clinical decision support

- Managing financial risk
  - Predictive modeling to health access and manage risk; provision of stop-loss coverage or reinsurance

Source: Aparna Higgins, Kristin Stewart, Kirstin Dawson and Carmella Bocchino, Health Affairs, 30, no.9 (2011):1718-1727, Early Lessons From Accountable Care Models In The Private Sector: Partnerships Between Health Plans And Providers

All models have shown Improvement

Quality and Outcomes
• Fewer ER visits; Fewer Readmissions

Improved Patient Satisfaction
•Expanded hours, more timely visits; Use of telehealth

Improved Medical Spend
• Avoided unnecessary costs; Decreased patient OOP

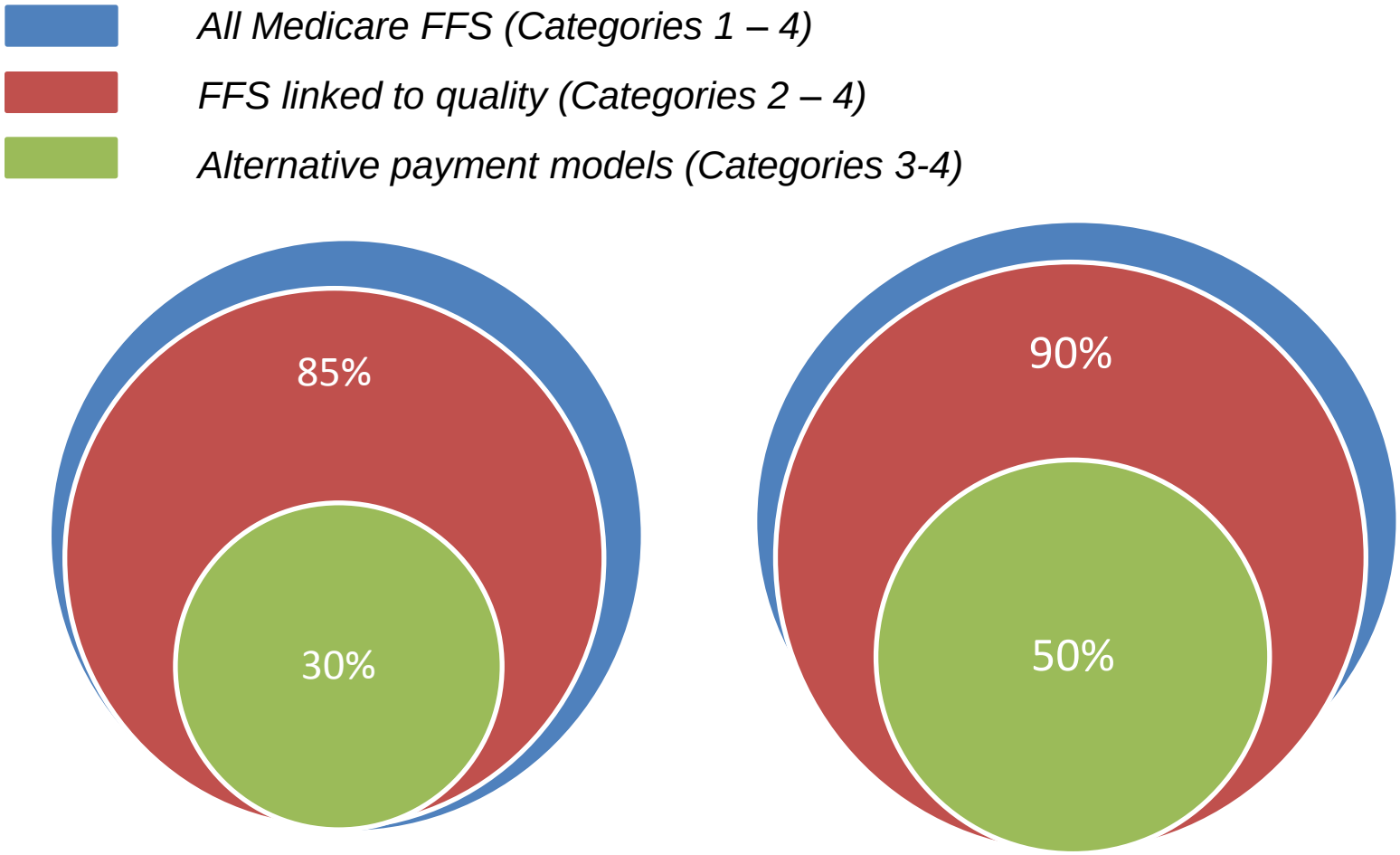
Patient-Centered Medical Home	Accountable Care Models	Episode/Bundled Payment
• $267 million in avoided costs • Reductions inpatient hospital admissions 3%-42% • Decrease in ER visits 6%-74%	• Shared savings amounted to > $50 Million • Increase in quality performance • Reduction in hospital readmissions by 15%-45%	• Consumers savings of 10-30% • Estimated overall procedural cost reductions of 34% • Increased screening rates by 72%

Framework for Progression of Payment to Clinicians and Organizations in Payment Reform

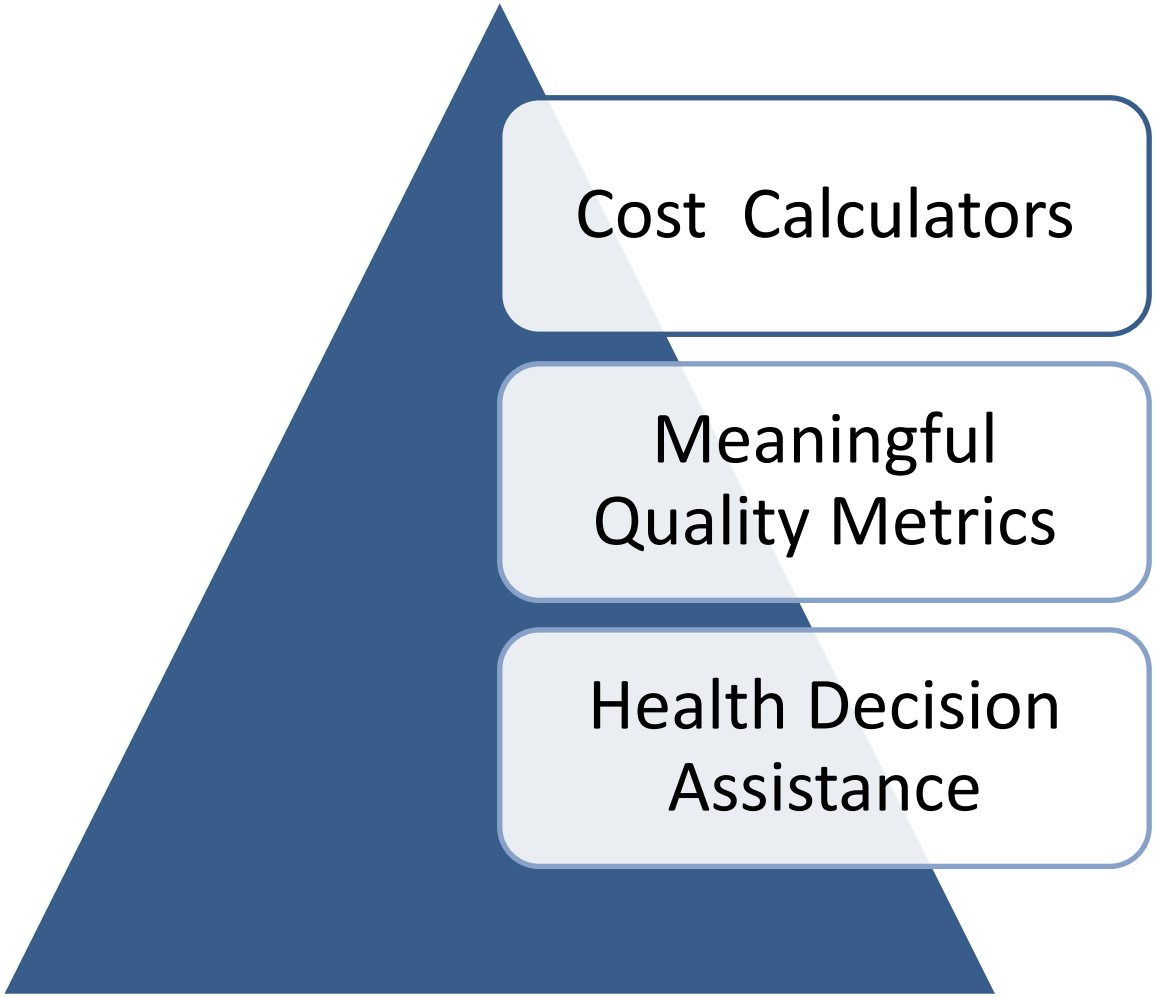
	Category 1: Fee for Service – No Link to Quality	Category 2: Fee for Service – Link to Quality	Category 3: Alternative Payment Models on Fee-for Service Architecture	Category 4: Population-Based Payment
Description	Payments are based on volume of services and not linked to quality or efficiency	At least a portion of payments vary based on the quality or efficiency of health care delivery	• Some payment is linked to the effective management of a population or an episode of care • Payments still triggered by delivery of services, but, opportunities for shared savings or 2-sided risk	• Payment is not directly triggered by service delivery so volume is not linked to payment • Clinicians and organizations are paid and responsible for the care of a beneficiary for a long period (eg, >1 yr)
Examples				
Medicare	• Limited in Medicare fee-for-service • Majority of Medicare payments now are linked to quality	• Hospital value-based purchasing • Physician Value-Based Modifier • Readmissions/Hospital Acquired Condition Reduction Program	• Accountable Care Organizations • Medical Homes • Bundled Payments	• Eligible Pioneer accountable care organizations in years 3 – 5 • Some Medicare Advantage plan payments to clinicians and organizations • Some Medicare-Medicaid (duals) plan payments to clinicians and organizations
Medicaid	Varies by state	• Primary Care Case Management • Some managed care models	• Integrated care models under fee for service • Managed fee-for-service models for Medicare-Medicaid beneficiaries • Medicaid Health Homes • Medicaid shared savings models	• Some Medicaid managed care plan payments to clinicians and organizations • Some Medicare-Medicaid (duals) plan payments to clinicians and organizations

Rajkumar R, Conway PH, Tavenner M. The CMS—Engaging Multiple Payers in Risk-Sharing Models. JAMA. Doi:10.1001/jama.2014.3703

Target percentage of Medicare FFS payments linked to quality and alternative payment models in 2016 and 2018



Changing the Dynamic of Patient Engagement



Price Transparency Tools

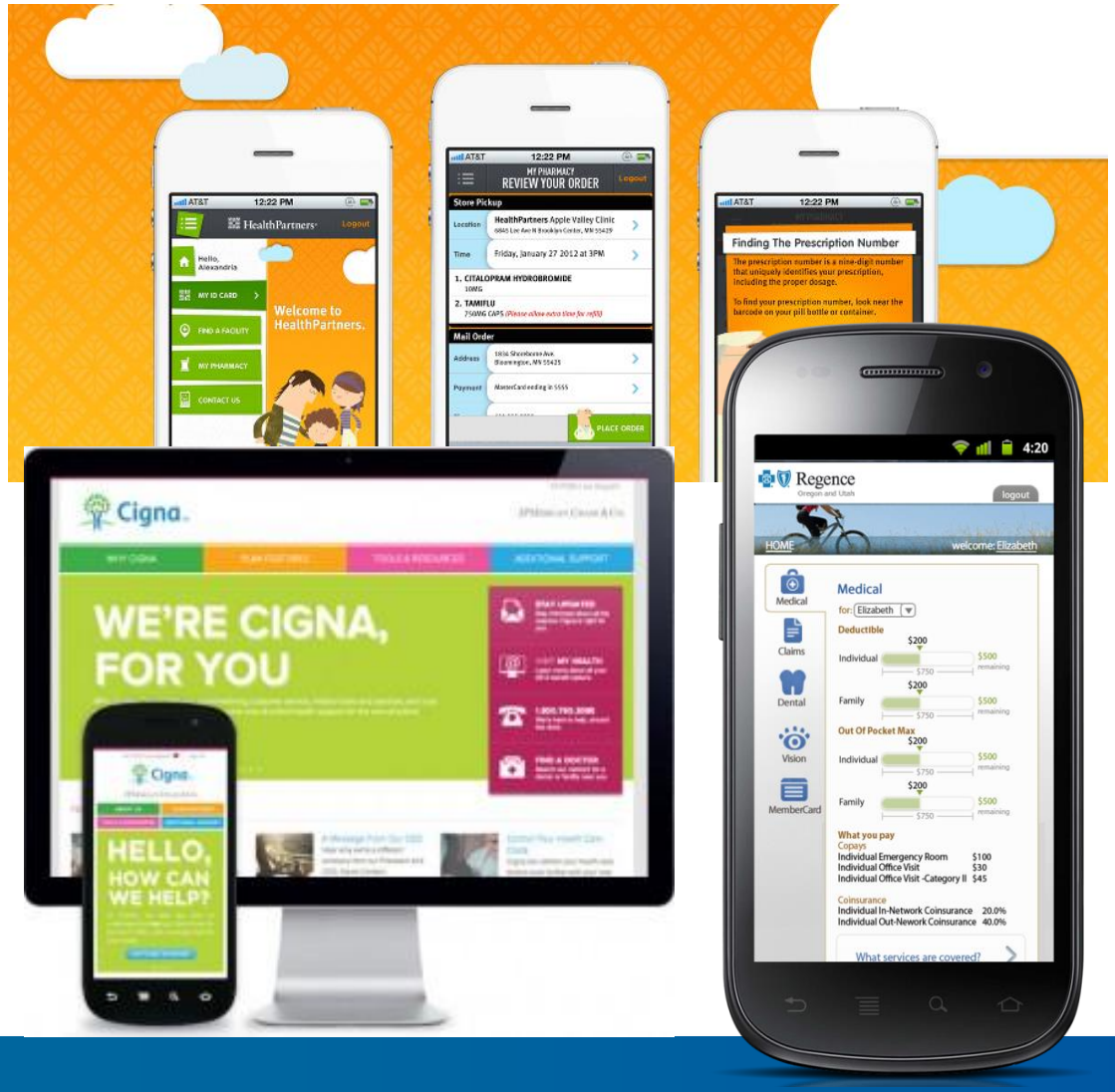
Aid consumer decision-making and provider selection:

- Estimates of frequency used services, including overall cost and the enrollee's share of cost;
- Linkage of price information to quality information where available; and
- Network status of providers

Use of mobile apps:

- Member services apps enable enrollees to submit and look up claims, view ID cards, review deductibles, and check account balances.
- Health care management apps enable members to set up preventive care alerts, access personal health records, order Rx refills, track workouts, food intake, and medications.
- Decision-making apps enable members to search for providers and facilities and compare drug costs.
- Medical support apps enable enrollees to contact an RN and access triage services.

Health Plan Mobile Applications



Provides members with access to information:

- Cost estimates – comparing prices of services; Search for providers and facilities
- Access ID card information; View claims and coverage
- Review claims, deductibles, out-of-pocket spending
- Preventive care alerts; Access to personal health records
- Track medications and order prescription refills
- Track workouts and food intake
- Contact with an RN and/or access to Triage services